2. A distinct program unit, or more than one, may be established by the county and certified by DHS to provide and be reimbursed FFP for the case management mode of service. The identified unit(s) will be required (1) to have a unique provider number, (2) to meet staffing standard requirements, and (3) to have ain place a utilization review system.

Case management services, whether provided by a certified SD/MC clinic or by a distinct program unit which provide case management services exclusively, shall be provided by or under the direction of Title 9, CCR, Sections 623, 624, 625, 627, 628, and 629 (minimum qualifications which apply to the head or chief of a particular service).

Case managers who will function under the supervision of the licensed professional noted above will include staff who are social workers (licensed and nonlicensed), nurses, marriage, family and child counselors, and, in some instances, staff with mental health experience but varied backgrounds who have been hired into job classifications of a generic nature, i.e., mental health specialists.

The State will require that supervisor/supervisees ratios for case management services be commensurate to the professionalism and experience of the case management staff. The local mental health director is held responsible to assure the quality of services provided subject to DMH and DHS oversight.

E. Qualification of Providers

The CSC, employed by the regional center, will be designated as the provider of TCM services. The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis. Case aides will do basic duties such as working by telephone with consumers and families. They assist in screening calls for services and frequently resolve requests for services. The case aides are employed by the regional center and work under the direct supervision of the CSC.

F. Additional Assurances

F-1 Mentally Disabled

County mental health programs which claim SD/MC reimbursement for case management services shall be required to provide and abide by the following assurances. DMH and DHS, as the single state agency, shall monitor to assure that:

1. Reimbursement

SD/MC reimbursement for case management services provided to residents of an inpatient hospital or skilled nursing/intermediate care (SNF/ICF) facility will be claimed only for evaluation and placement services. Those case management services, as defined in Attachment to Supplement 1 to Attachment 3.1-A, will not be allowed as a substitute for or as a part of the screening and other requirements of Public Law 100-203 (Nursing Home Reform).

FFP for case management evaluation and placement services provided to residents of an inpatient hospital or an SNF/ICF will be limited to a period of 30 days immediately prior to the eligible individual's discharge from the facility to noninstitutional care. Moreover, while acknowledging that, for a variety of possible reasons, discharge may not always materialize as planned; the State, nevertheless, will limit reimbursement for such case management services to a maximum of 3 nonconsecutive episodes of 30 days or less per institutional stay.

2. Record Keeping/Utilization Review

Record keeping/utilization review requirements are fully implemented.

DMH utilization review standards for case management services will be similar to those which have been developed and implemented for hospital impatient and outpatient clinic services. DMH will develop an appropriate utilization review protocol which will be submitted to DHS for review and concurrence prior to implementation.

DMH shall require local mental health programs and providers of case management services to utilize existing systems, or establish necessary additional systems, to review the quality and appropriateness of case management services funded by Medi-Cal and shall audit for compliance. County or provider utilization review committees should anticipate that DMH utilization review audits shall:

a. Verify that providers of case management services have a continuous operational program of utilization review in effect under which the admission of each client for case management services is reviewed for approval.

b. Verify that the client meets the criteria established for the target population.

c. Verify that the county/provider has established criteria, and applied that criteria, to evaluate the need for case management services and for termination of case management services.

d. Verify that the need for case management services has been established and clearly documented. The initial review by the county or provider's utilization review committee shall be within 60 days of the client's admission for case management service; subsequent reviews shall be scheduled, at a minimum, every 6 months.

e. Verify that the case management service plan (goals, objectives, time frame) are appropriate to the identified need(s) and that the interventions of the case manager are appropriate to the goals, objectives, and projected time frame.

f. Identify and recoup inappropriate payments of FFP.

g. Provide an administrative mechanism for providers who wish to appeal a review finding.

F. Additional Assurances

F-2 Developmentally Disabled

No assurances.